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To: ALL INTERESTED PARTIES

From: Department of Managed Health Care

The following is a brief summary of the comments and events that occurred during the Financial Solvency Standards Board (FSSB) meeting held on January 31, 2006.

## I. Opening Remarks and Adoption of Meeting Minutes

Acting Advisory Committee Chairperson Tom Davies called the meeting to order at 10:00 A.M. The Board members unanimously approved minutes from the August 23, 2005 meeting.

## II. SB 260 Update (Rick Martin)

Rick Martin gave an update on the first quarterly financial reports from the Risk-Bearing Organizations. A review of the requirements and preliminary results were presented. The first reports were due November 15, 2005.

## III. Presentations on Quantifying the Value of the Integrated Care Delivery Model

The following presentations on quantifying the value of the integrated care delivery model were delivered to the Board:

A. Measuring Delivery System Quality and Efficiency (Presentation by Chris Ohman, President and CEO of California Association of Health Plans)

- Challenges in the use of metrics. To quantify the quality and efficiencies of the integrated care delivery model.
- 55% of patients receive the recommended care. (45% error rate.)
- Several organizations are working on quality and efficiency metrics, but the work is slow and arduous.
- Score keeping must be fair to all involved.
- Purchasers are key drivers.
- Metrics should be appropriate for the corresponding audience. For example, large purchaser and consumers may rely on different metrics.

- Organizations include IHA pay-for-performance, NCQA, the National Quality Forum, and Leapfrog.
- Efficiency. Challenge is the transparency of health care pricing.

B. Measuring the Effectiveness of the Coordinated Care Model (Don Crane, President and CEO of California Association of Physician Groups; Bart Asner, M.D., CEO of Monarch HealthCare; and Don Rebhun, M.D., President and Medical Director of Greater Valley Medical Group, Inc.)

Overview of the advantages of the delegated model.

- Differing characteristics of the coordinated model. Integrated Clinical Data. Coumadin Clinics. Referral Programs.
  Example: Coumadin Clinics. Coumadin is a drug whose proper dosage is difficult to pinpoint for different patients. With the coordinated model, can create a special clinic with expertise in determining the proper dosage. This can lead to cost savings.
- Process measures. Did the event happen? Examples, cholesterol measurement, immunizations, pap smears, etc.
- Efficiency and Effectiveness. Chronic Disease metrics (admits, readmits), Repeated Diagnostics (MRI, CT, PET).
- Need to define metrics and invest in data gathering, analysis and reporting.

C. Example of How the Delegated Model Works for Patients (Ron Bangasser, M.D. FAAFP, Director of External Affairs for Beaver Medical Group)

Presentation was a medical group's perspective of the advantages of the delegated model.

- Health Care is local. Delegated model is quicker.
- Control of UR, CQI and Credentialing. HMO's exercise oversight.
- Coumadin Clinic. 87% in proper range compared to 37% previously.
- Asthma program. Reduced risk of hospitalization nine times for the 17 and under population as well as the 55 and over population.
- Auto Authorizations within the group. (Numbers are monitored.) Outside referral outcomes are tracked.
- Group delivers more care appropriately, faster, with more accuracy and with more available data.

D. California Pay-for-Performance (Presentation by Tom Williams, Executive Director of Integrated Healthcare Association)

- Goal: Create incentives that will drive breakthrough improvements in performance through common set of measures, public scorecard, and significant health plan payments.

- Has created collaborative program, common set of measures, which has improved data collection and a mechanism for aggregating physician group data across health plans. Aggregated data produces more valid reporting.
- Examples of improvements include breast cancer screening, cervical cancer screening, cholesterol screening, etc.
- Single public report is a reality.
- CA v the Nation. California is below national average on most measures for 2003. California tends to be lower regardless of data source, although California's efficiency seems to exceed the nation.
- Goals for 2010. Incentive payments of up to 10% of total physician group compensation.

E. Quantifying Delivery Model Value: An Analysis of Healthcare Costs (Presentation by Barbara Wochsman and Anil Kochhar of Aon)

- Health plan marketplace has shifted and evolved. Factors in evaluating the shift include cost data (which is limited) and utilization data.
- Database includes self-funded cost data.
- Evaluation of costs is difficult due to the varying pricing practices involving HRA/HSA funds.
- Issues: Which model is most efficient? Will PPO plan designs reduce long-term healthcare cost trends? Which model improves quality of care?
- Standard products include HMO/EPO, PPO/POS, and CDHP. National average costs HMO ($3959), PPO ($4288), and CDHP ($3625)

## IV. Closing Remarks/Next Steps

The next meeting will be scheduled in March, 2006 (Note: The meeting in March was cancelled and rescheduled for August 9, 2006, at the Sheraton Grand in Sacramento).